

HOSPICE SERVICES PAYMENT SYSTEM

payment**basics**

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The Medicare hospice benefit covers a broad set of palliative services for beneficiaries who have a life expectancy of six months or less, as determined by their physician. Beneficiaries who elect the Medicare hospice benefit agree to forgo curative treatment for their terminal condition. For conditions unrelated to their terminal illness, Medicare continues to cover items and services outside of hospice. Typically, hospice care is provided in patients' homes, but hospice services may also be provided in nursing facilities and other inpatient settings. Hospice providers can be freestanding entities or based in hospitals, skilled nursing facilities, or home health agencies.

CMS data show substantial growth in use of the hospice benefit among Medicare beneficiaries and associated program spending since 2000. The share of Medicare decedents using hospice has increased from about 23 percent in 2000 to more than 50 percent in 2017. About 1.49 million beneficiaries used hospice in 2017, compared with 0.53 million in 2000. The total number of providers has also increased. The number of hospice agencies participating in the Medicare program has nearly doubled between 2000 and 2017, for a total of about 4,488 providers in 2017. In addition, as of 2017, about 69 percent of hospice agencies were for profit, compared to about 30 percent in 2000. Medicare payment for hospice grew from almost \$3 billion in 2000 to \$17.9 billion in 2017.

The hospice benefit and Medicare payment

The hospice benefit is designed to provide pain relief, comfort, and emotional and spiritual support to patients with a terminal diagnosis. To provide this type

of care, the benefit covers an array of services, such as:

- skilled nursing services;
- drugs and biologicals for pain control and symptom management;
- physical, occupational, and speech therapy;
- counseling (dietary, spiritual, family bereavement, and other counseling services);
- home health aide and homemaker services;
- short-term inpatient care;
- inpatient respite care; and
- other services necessary for the palliation and management of the terminal illness.

Setting the payment rates

Medicare pays hospice agencies a daily rate for each day a beneficiary is enrolled in the hospice benefit (Figure 1). Medicare makes a daily payment, regardless of the amount of services provided on a given day and on days when no services are provided. The daily payment rates are intended to cover costs that hospices incur in furnishing services identified in patients' care plans. Payments are made according to a fee schedule that has four different levels of care: routine home care (RHC), continuous home care (CHC), inpatient respite care (IRC), and general inpatient care (GIC) (Table 1).

Hospice payment rates are updated annually by the hospital market basket. The market basket index is reduced by a productivity adjustment. Beginning fiscal year 2014, hospices that do not report quality data receive a 2 percentage point reduction in their annual payment update.

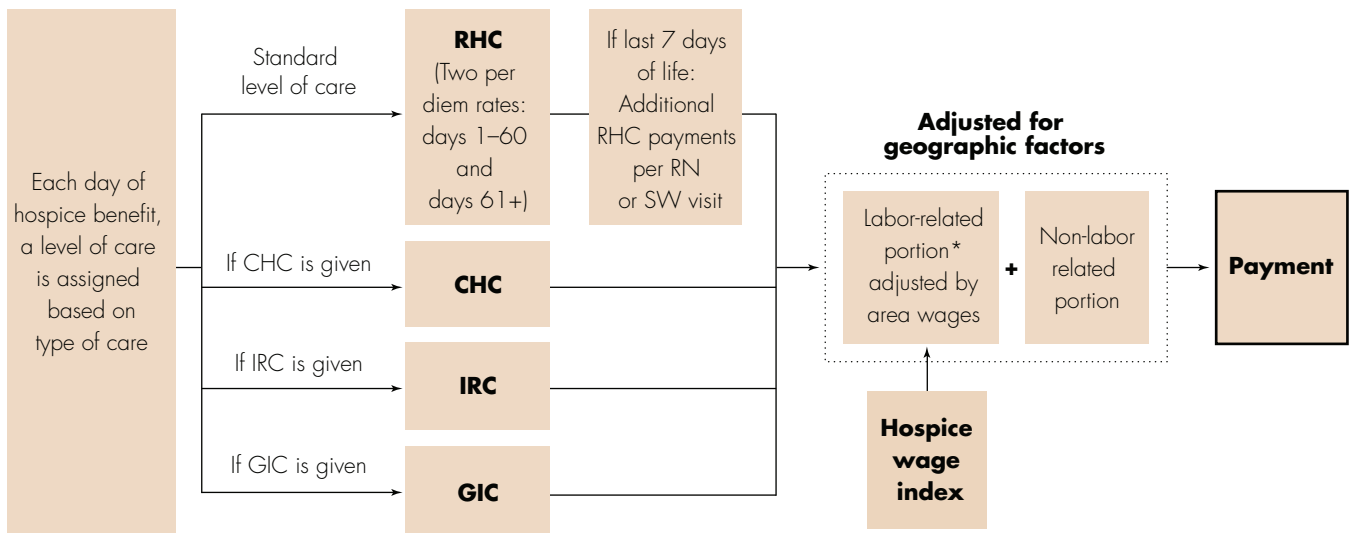
The four levels of care are distinguished by the location and intensity of the services provided. RHC is the most common level

*This document does not
reflect proposed legislation
or regulatory actions.*

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Figure 1 Hospice prospective payment system



Note: RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care), RN (registered nurse), SW (social worker).
 *The labor-related portion adjusted by the wage index varies, depending on level of care (see Table 1). Wage index adjustment is based on the location of the patient, not the hospice agency.

of hospice care, accounting for about 98 percent of all hospice days. Other levels of care—GIC, CHC, and IRC—are available to manage needs in certain situations. GIC is provided in a facility on a short-term basis to manage symptoms that cannot be managed in another setting. CHC is

intended to manage a short-term symptom crisis in the home and involves eight or more hours of care per day, mostly nursing. IRC is care in a facility for up to five days to provide an informal caregiver a break. Unless a hospice provides CHC, IRC, or GIC on any given day, it is paid at the RHC

Table 1 Hospice levels of care and rates

Level of care	Description	Base payment rate, FY 2020	Labor-related portion of payment adjusted by the wage index, FY 2020
RHC*	Home care provided on a typical day: Days 1–60	\$195	69%
	Home care provided on a typical day: Days 61+	154	69
CHC	Home care provided during periods of patient crisis	1,396	69
IRC	Inpatient care for a short period to provide respite for primary caregiver	450	54
GIC	Inpatient care to treat symptoms that cannot be managed in another setting	1,021	64

Note: FY (fiscal year), RHC (routine home care), CHC (continuous home care), IRC (inpatient respite care), GIC (general inpatient care). Payment for CHC is an hourly rate (\$58.15 per hour, with maximum payment per day equal to about \$1,396) for care delivered during periods of crisis if care is provided in the home for 8 or more hours within a 24-hour period beginning at midnight. In addition, a nurse must deliver half of the hours of this care to qualify for CHC-level payment. The above rates apply to hospices that submit the required quality data. The rates are 2 percentage points lower for hospices that do not submit the required quality data.
 *In addition to the daily rate, Medicare pays \$58 per hour for registered nurse and social worker visits (up to four hours per day) that occur during the last seven days of life for beneficiaries receiving routine home care (this is referred to as the *service intensity adjustment*).

Source: CMS Manual System Pub 100–04 Medicare Claims Processing, Transmittal 4086, “Update to Hospice Payment Rates, Hospice Cap, Hospice Wage Index, and Hospice Pricer for FY 2020.” August 16, 2019.

rate. For any given patient, the type of care can vary throughout the hospice stay as the patient's needs change.

Historically, each level of care has been associated with its own base payment rate. The different base rates reflect variation in expected input costs across the levels of care.

Prior to January 2016, Medicare had a single base rate for each RHC day in an episode. Beginning January 1, 2016, Medicare changed how it pays for RHC. There are now two RHC base payment rates: a higher rate for days 1 to 60 and a lower rate for days 61 and beyond. In addition, Medicare makes additional RHC payments for registered nurse and social worker visits that are provided during the last seven days of life.

These changes to the structure of RHC payments were the first changes to the hospice payment system since its inception in 1983. The new RHC payment structure is intended to better align payments with the costs of providing hospice care throughout an episode. Hospices tend to provide more services at the beginning and end of an episode and less in the middle. The new payment structure better matches that pattern of care than a single RHC base rate.

For fiscal year 2020, CMS increased the payment rates for the three higher intensity levels of hospice care (CHC, IRC, GIC) to better align with their estimated cost according to the Medicare cost report. For fiscal year 2020, the payment rates increased 40 percent for CHC, 156 percent for IRC, and 35 percent for GIP over their 2019 levels. To offset the projected increase in spending, the payment rates for RHC in fiscal year 2020 were reduced slightly (by less than 1 percent). Although CMS estimated that the RHC payment rates exceeded costs by 18 percent to 19 percent in 2019, the statute requires that any rebalancing of the payment rates be budget neutral.¹ Because RHC accounts for about 98 percent of hospice days, only a small decrease in the RHC rates was

needed to offset the increases for the three less frequent levels of care.

The daily hospice payment rates are adjusted to account for differences in wage rates among markets. Each level of care has a labor share and a non-labor share; those amounts differ across each level of care, reflecting the estimated proportion of input costs that is attributable to wage and non-wage costs. The labor share of the base payment amount is adjusted by the hospice wage index for the location in which care is furnished and the result is added to the non-labor portion.

Two caps limit the amount and cost of care that any individual hospice agency provides in a single year. One cap limits the number of days of inpatient care an agency may provide to not more than 20 percent of its total patient care days. The other cap is an absolute dollar limit on the average annual payment per beneficiary a hospice can receive. If a hospice's total payments exceed its total number of Medicare patients multiplied by \$29,964.78 for fiscal year 2020, it must repay the difference. Unlike the daily rates, this cap is not adjusted for geographic differences in costs. The hospice cap is adjusted annually by the medical expenditure category of the consumer price index for all urban consumers.

Beneficiary liability for hospice services is minimal. Hospices may charge a 5 percent coinsurance for each drug furnished outside of the inpatient setting, but the coinsurance may not exceed \$5 per drug. For inpatient respite care, beneficiaries are liable for 5 percent of Medicare's respite care payment per day. Beneficiary coinsurance for respite care may not exceed the Part A inpatient hospital deductible, which was \$1,364 in 2019. ■

1 Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2019. Medicare program; FY 2020 hospice wage index and payment rate update and hospice quality reporting requirements. *Federal Register* 84, no. 151: 38484–38544.